Compliance Efforts Get Some PEPP

by Gloryanne Bryant, ART, CCS

Earlier this year, the Office of the Inspector General (OIG) informed the Health Care Financing Administration (HCFA) that "the DRG system is vulnerable to abuse by providers who wish to increase reimbursement inappropriately through upcoding, particularly so within certain DRGs."

The OIG encourages and supports additional efforts to monitor and oversee DRG coding. In fact, the OIG recommended that HCFA perform "routine monitoring and analysis of hospital billing data and clinical data to proactively identify aberrant patterns of upcoding." In light of such increased vigilance, HCFA has asked its peer review organizations (PROs) to engage in local and special projects to address the issue of DRG validation. This will be accomplished under the sixth scope of work (SW), as a payment error prevention program (PEPP) that went into effect August 1, 1999. The state PROs will initiate the program on a regional basis with different start-up dates.

PEPP will be administered through the PROs in every state, including the District of Columbia, Puerto Rico, and the Virgin Islands. The PROs were chosen for this program based upon a successful history with both the American Medical Association and the American Hospital Association in their collaborative efforts to improve the quality of healthcare. The involvement of the PRO for PEPP is limited to inpatient prospective payment system hospital services.

The government estimates that improper Medicare payments made in fiscal year 1998 totaled $12.6 million. PEPP is designed to help ensure that Medicare hospital inpatient claims are billed and paid appropriately. It also recognizes that the majority of payment errors are the result of people attempting to use and manage a very complex system—not fraud. Medicare fraud is defined as an intentional misrepresentation to obtain payment.

How PEPP Works

All state PROs will be required to conduct DRG validation studies during the first year of work in order to monitor hospitals for coding accuracy. In addition, the PROs will engage in corrective action plans when necessary, especially during the first year of the program. The DRG validation studies performed by the PROs will include trend analysis and target identification. The effort includes a national DRG surveillance sample, conducted by clinical data abstraction centers (CDACs), to be continued and expanded to identify other types of payment and utilization errors, such as unnecessary services, inappropriate settings, and poor quality of care. Data analysis conducted by the CDACs will help pinpoint highly vulnerable DRGs to upcoding, which the PROs will utilize.

Under inpatient PPS, each PRO will coordinate its efforts and develop relationships with state agencies, other HCFA contractors, fiscal intermediaries, and those responsible for law enforcement of the Medicare program. The PRO will develop the capability to identify types of payment errors within each state. This may include pattern analysis of billing data and the review of individual records. The PROs will also help identify trends and patterns that suggest insufficient or poor documentation, incorrect DRG assignment, inappropriate transfers, premature discharges, and inappropriate, unreasonable, or medically unnecessary care. The PROs will look at the nature and extent of the errors in each state. This data and analysis will provide work plans and goals for the PRO for the second and third years of their work.

Development of intervention measures also will become the PROs' responsibility. The rationale behind this is that information sharing and a reduction in errors should take place. Improvements will be assessed, and that information and data will be used for taking appropriate action to improve upon the target(s) error rates.

If the PRO identifies potential quality of care issues, including inappropriate or substandard care and unreasonable or unnecessary services, it will refer these cases to mandatory review. The PRO will also refer information regarding any opportunities to improve the quality of care to the PRO's quality improvement staff. If unnecessary services, fraud, waste, or

abuse is discovered, appropriate review and referrals to the fiscal intermediary and the appropriate law enforcement agencies will be made.

During the course of the PRO work, medical records will be requested from the provider—either for case review or for data collection. The California PRO (CMRI) has stated that they will review these DRGs—079/089, 320/416, 128/ 130, and 087/127—as well as others.

Another component of PEPP is a surveillance system, which will reside under a separate contract to provide the PRO with a statewide baseline payment error rate. HCFA will set a program goal and direct efforts to achieve a 50 percent relative reduction. Each PRO will be evaluated and will be determined to be successful if it:

- achieves at least a 10 percent relative reduction in the payment error rate
- performs the required first-year project within the agreed-upon time frames
- conforms to all reporting requirements as outlined in the PRO manual
- establishes contact and coordination with local, state and federal agencies and contractors and pertinent law enforcement agencies

The PEPP task descriptions offer opportunities for the PRO to establish working relationships with hospitals, medical staff, and their state associations for advice and assistance in the program's implementation. This provides hospitals and practitioner communities with a reasonable opportunity to comment on program development. Additional input will focus on the criteria used to identify trends and patterns and to make reliable and consistent determinations for appropriate interventions on incorrect payments. Talk to your state PRO and ask about PEPP. Gather information and share it with your facilities and organizations. And take advantage of opportunities to become an HIM representative within the PROs.

Two Specific Target Errors

The OIG's Office of Audit Services Opinion (from HCFA's 1997 financial statement) identified two specific areas for payment error reduction. The two areas identified are:

- unnecessary admissions—inpatient services not requiring hospitalization or more appropriate treatment in alternative settings
- upcoded DRG assignments—determine where incorrect assignments have occurred and provide intervention to reduce these errors

More information about this report can be found on the HCFA Web site at www.hcfa.gov.

In addition to the above-mentioned activities, the OIG will pilot a program of inpatient Medicare review at a selected fiscal intermediary. The pilot program will routinely use CDAC/PRO data and fiscal intermediary inpatient hospital data to identify aberrant coding, billing, utilization, and expenditure patterns to target review in vulnerable areas.

References

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